

## MEDICAID RESOLUTION INQUIRY

MAIL TO:  
EDS PROVIDER SERVICES  
P O BOX 300009  
RALEIGH, NC 27622

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Please Check: ☐ Medicare Override ☐ Time Limit Override ☐ Third Party Override

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES AND INQUIRIES ONLY**.  
CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.  
***ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.***

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Provider Number: \_\_\_\_\_

Provider Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Recipient ID: \_\_\_\_\_

Date of Service: From:    /    /    to    /    / Claim Number: \_\_\_\_\_

Billed Amount: \_\_\_\_\_ Paid Amount: \_\_\_\_\_ RA Date: \_\_\_\_\_

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Please Specify Reason for Inquiry Request:

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Signature of Sender: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

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### TO BE USED BY EDS ONLY

Remarks: